Intake procedures should be initiated upon referral to the Community Follow-up Program provider and completed after the first visit. The Intake procedures may be completed by the case manager, technician or the community follow-up worker. The intake includes confirmation that the case management program has been fully explained to the client. Clients have the right to choose care providers and, therefore, may choose whether or not to enroll in the case management program.

2. Assessment

Assessment is the collection of information about the client's medical, physical and psychosocial condition, resources, needs, and confirmation of eligibility for the program. The assessment process should include a home visit to evaluate the client's needs, informal supports, and general living conditions. All family members should be seen in the assessment interview(s), if possible. Direct caregivers and family members not able to be interviewed should be contacted by phone, if possible. The purpose of assessment is to identify the client's/family's problems and care needs, what care needs are being met and by whom, and what needs are not adequately met. The initial assessment will focus on immediate health and social services needs and address the client's history of underutilization of care, and the reasons for such underutilization. Assessments will be documented on forms required or approved by the State Department of Health, AIDS Institute.

Assessment activities should be completed following the second visit but no later than 15 days from the date of receipt of the referral. The assessment should be completed by the case manager with assistance from the case management technician.

3. Initial Service Plan Development

Development of the service plan is the translation of assessment information into specific goals and objectives, and specific services, providers and timeframes to reach each objective. The service plan is developed by the case manager, in coordination with the client, representative and other providers.

The service plan will reflect goals and services to be provided to the client and family members. If services actually provided differ, a note explaining the difference should be made. The costs and sources of payment for all services should be documented as required by Department of Social Services regulations 505.16. The client's response to the final plan, consent to case management and/or declination of any part of the plan by the client should be documented on forms approved by the Department of Health.

It is the intent of New York State that case management in the Community Follow-up Program represent a fully integrated case management approach. The case manager coordinates all necessary services along the continuum of care - both institutional and community based by both directly accessing services and by establishing linkages with other service programs including those under the jurisdiction of the local department of social services. The role of the case manager is to reduce the barriers in crossing administrative boundaries to ensure that clients obtain needed services at the appropriate time from wherever the services are available. Services accessed for the client should include institutional and non-institutional medical and non-medical services, social and other support services and linkages to existing community resources. In so doing, the case manager will access and coordinate services with other case managers who may also serve the client. The service plan will be developed following the second client contact. Immediate needs should be addressed by the case manager and such services should be implemented immediately after the intake. Other assessed needs should be addressed as soon as possible but in no case later than 30 days from the date of receipt of the referral. The service plan is to be developed by the case manager with the assistance of the technician or community follow-up worker.

4. - Initial Service Plan Implementation

In implementation of the service plan, or service acquisition, the case manager assists the client and family or coresidents as needed, in contacting the support persons and other service providers to negotiate the delivery of planned services. The service plan may be modified to accommodate the client, family members, coresidents, support persons, and service providers. Any changes from the original plan should be noted in the record. These activities may be accomplished by the case manager or a member of the case management team.

The case manager, case management technician or community follow-up worker will (in accordance with the client's assessed abilities):

a. contact providers, including support persons, by phone, in writing or in person
b. assist the client and family members or coresidents in making applications for services and entitlements, including basic needs such as transportation, child care, baby-sitting, etc.
c. confirm service delivery dates with providers, and supports
d. schedule multiple visits by family members on the same day to accommodate the needs of the family and children
e. document services that aren't available or cannot be accessed

f. gain assurance from other care providers that services will be initiated, and confirm the delivery of these services
g. decide, with the client and other providers, on the ongoing responsibilities of each provider
h. give other service providers accurate and complete information about the service(s) they are expected to provide and the services provided by others.

Any changes to the service plan due to scheduling or availability of services will be documented. Service plan implementation should begin immediately after service needs are assessed and is an ongoing responsibility of the case manager. The case manager and support staff, in accordance with the client's assessed abilities, will assist the client by contacting providers and support persons when needs are identified. Assistance continues until the case manager or staff determines that the services have been arranged and received. Confirmation of need for, application for and receipt of services is required.

5. Reassessment

Reassessment is a scheduled or event generated formal re-examination of the client's situation, functioning, clinical and psychosocial needs, to identify changes which have occurred since the initial or most recent assessment. The reassessment should measure progress toward the desired goals outlined in the care plan and is used to prepare a new or revised service plan or confirm that current services remain appropriate. Reassessment is the responsibility of the case manager.

A formal reassessment under the program for clients who are receiving intensive case management is due within 90 days of admission and every 90 days thereafter or when a change in the client's status occurs which significantly effects the service plan. Significant changes in status include:

a. death, illness or hospitalization of a family member or care giver(s), or a condition or circumstance which impairs the client's ability to provide for the family's physical and/or emotional needs,
b. change in the client's clinical or functioning status,
c. loss of domicile, entitlement, or service.

6. Service Plan Update

Updating the service plan means modification to or revision of the service plan based on reassessment. Update of the service plan may also occur as a result of changes in clients' needs, or information from monitoring contacts when changes are not significant as to require a formal reassessment. Update of the service plan includes all activities of service plan development, described above in subsection c, relative to new or changed needs and services. The service plan should be updated at every reassessment or when a change in client status occurs which significantly affects the service plan. The service plan may be updated by the case manager with assistance from the members of the case management team.

7. Service Plan Update Implementation

Implementation of the updated service plan includes the same activities as described for service plan implementation noted in subsection d, and may be the responsibility of the technician or community follow-up worker under the supervision of a case manager.

8. Monitoring

Monitoring is contact between the case manager or support staff and the client or representative. Support persons and service providers will also be contacted if necessary. The purpose of these contacts is to assure that services are being delivered according to the service plan. Contacts may include encounters in the agency, home, hospital or outpatient department, contacts by phone or in person. Any problems noted during monitoring contacts will be followed up immediately with the client, support person or provider, as needed, to address the problem.

The case manager and case management team will also coordinate the medical monitoring of all persons who are HIV positive with the primary care physician, clinic or AIDS Center responsible for the medical monitoring of asymptomatic HIV disease. This service includes the ongoing monitoring of preclinical HIV infection (asymptomatic) to determine the appropriate stage to initiate active prophylactic and secondary treatment for opportunistic infections. This service applies to HIV positive persons prior to clinical manifestations or laboratory evidence of HIV illness. The case manager should assure that CD4 ((T4)) testing is done every three or six months as appropriate, and if symptoms of HIV illness are identified, therapies provided by a referral to an AIDS Center hospital or appropriate outpatient department be arranged. Periodic testing for persons at risk, when requested, or when high risk behavior is reported or suspected should also be arranged by the case manager and case management team.

For clients receiving intensive case management in the Community Follow-up Program, a minimum of 9 contacts is required every 90 days. A minimum of six of these contacts must be face to face with the client. A minimum of four of these contacts must be home visits. Greater frequency of contacts in all categories will be arranged on an as needed basis and are in fact encouraged and anticipated in an intensive case management program. The case manager must personally have two contacts with the primary client every 90 days. Case conferences will be held for families with multiagency service plans including agencies such as Certified Home Health Agencies, local child welfare or community based organizations. Conferences will take place within 90 days of initial care plan implementation and every 180 days thereafter.

9. Crisis Intervention

The purpose of crisis service is to provide assessment and intensive short term treatment of acute medical, social, physical or emotional distress. Crisis intervention should be made available to all Community Follow-up Program clients on an emergency 24 hour basis through subcontract with a 24 hour crisis agency, or via direct provision by the case manager, by a crisis hotline, use of mobile crisis teams, or through referral to the Community Follow-up Program Director or supervisor. Crisis services may be needed for a variety of reasons. The crisis may relate to an emergency medical need, drug use or drug overdose, domestic violence or child abuse, etc. Irrespective of the nature of the crisis, it is the responsibility of the case manager or provider agency to assist the client, family, coresident or lover in obtaining the appropriate response to the situation, keeping in mind the need to maintain the client's dignity and rights to privacy and confidentiality. In addition, the crisis intervention should be designed to decrease inappropriate utilization of emergency rooms by targeting the response more appropriately to the identified crisis.

TN 90-42 Approval Date OCT 10 1991
Supersedes TN New Effective Date JUL - 1 1990

10. Exit Planning/Case Discontinuations

Exit planning procedures are initiated when the client:

a. expires
b. loses Medicaid or programmatic eligibility, though Medicaid eligibility is not required for eligibility in the CFP, or
c. declines the case management services of CFP, or
d. desires to be referred to a different CFP provider agency or to an existing case management program such as the Long Term Home Health Care Program, AIDS Home Care Program, or
e. will be institutionalized for greater than 30 days if Medicaid is the payor for such hospitalization and discharge to community based care is not anticipated. For private pay and third party individuals, case management services may continue beyond the 30 day limit while hospitalized, or
f. the client relocates out of the CFP providers' service area.

In all cases, except where the client expires, the provider must complete a referral process designed to link the client with appropriate ongoing case management and other vital services necessary to meet their care needs. The provider must refer the client to another eligible CFP provider if one exists within the geographic area in which the client resides. With the client's consent, a case summary should be prepared for referral to the new provider. A final assessment noting disposition and measures of progress toward identified goals should be prepared and placed in the final record. The local Department of Social Services should be notified of the case disposition and can assist in referral of the client to alternate case management providers. Exit planning is a responsibility of the case manager with assistance from the members of the case management team.

11. Patient Advocacy, Interagency Coordination and Systems Development

The function of the case manager is to be an advocate for services for the client with particular emphasis on self-sufficiency in the community and avoidance of premature or unnecessary institutionalization.

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12. Supervisory Review/Case Conferencing

An important component of the required quality assurance process for each CFP provider will be supervisory review of case management documentation, care plans and other products as well as peer review or case conferencing with other case managers. Therefore, for clients receiving case management, supervisory review of each client care plan by the designated supervisor or agency director will be conducted initially at the time of the development of the original service plan and every 90 days thereafter. In addition, each agency participating as a CFP provider will establish a peer review process wherein all case managers will present and discuss client specific case management plans with other case managers in the agency at least once annually. While we are requiring the supervisory function, we are not requiring a supervisory role. In this way agencies will have the flexibility to provide supervision with either in house staff or through an outside consultant.

Case managers will also be required to case conference with other agencies regarding specific clients at 90 days after service plan implementation and every 180 days thereafter, taking into consideration client consent, the client's need for confidentiality and privacy, as well as Department of Health Regulations on confidentiality. This would include contacts with discharge planners, case managers from other agencies, etc. Supervisory review and case conferencing are billable on a direct patient specific basis in the community Follow-up Program. Agency conferences that are not patient specific are not directly billable; however, projected costs for these activities may be included in the administrative budget submitted by each provider.

13. Program Limitations

Case Management under the Community Follow-up Program:

1. must not be utilized to restrict the choice of a case management services recipient to obtain medical care or services from any provider participating in the Medical Assistance Program that is qualified to provide such care or services and who undertakes to provide such care or service(s) including an organization which provides such care or services or which arranges for the delivery of such care or services on a prepayment basis;

2. must not duplicate certain case management services currently provided under the Medical Assistance Program or other funding sources such as the Long Term Home Health Care Program, AIDS, Home Care Program under Chapter 622 of the Laws of 1988, and the Care at Home Program (Katie Beckett Model Waivers).

3. must not be utilized by providers of case management to create a demand for unnecessary services or programs, particularly those services or programs within their scope of authority; and

4. must not be provided to persons receiving institutional care for more than 30 days or when discharge to community based care is not anticipated and care is reimbursed under the Medical Assistance Program. Case management services may be provided for children and family members during this period of hospitalization.

While the activities of case management services secure access to, including referrals to and arrangements for, an individual's needed service, reimbursement for case management does not include:

1. the actual provision of the service;
2. Medicaid eligibility determinations/redeterminations;
3. Medicaid preadmission screening;
4. prior authorization for Medicaid services;
5. required Medicaid utilization review;
6. administration of Child-Teen Health Program Services;
7. activities in connection with "lock-in" provisions under 1915(a) of the social Security Act;
8. institutional discharge planning as required of hospitals, SNFs, ICFs and ICF/MRs; and
9. client outreach.

E. QUALIFICATIONS

1. Provider Qualifications

Provider agencies applying for participation in the Community Follow-up Program must meet one of the following requirements:

(a) have 2 years demonstrated experience in the care of the clients with HIV related illnesses or in providing case management or other services to clients with HIV illness. Examples of eligible agencies will include: Article 28 facilities, Community Based Organizations (CBOs), Community Health Centers (CHCs), or Community Service Programs (CSPs), Certified Home Health Agencies (CHHAs), or

(b) have 3 years demonstrated experience in the provision of maternal/pediatric services or in providing case management or care planning services to prenatal or post partum women and their children or families, or

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(c) have 3 years demonstrated experience in the provision of drug abuse and/or drug treatment services, foster care preventive services or adult protective services including case management to clients and families that are at risk of foster care, including but not limited to local departments of social services, or

(d) be a hospital that has a provider agreement with the New York State Department of Health to participate in the Department's Obstetrical HIV Counseling/Testing/Care Initiative.

2. Staff Qualifications

A. Case Manager Qualifications

To be eligible for reimbursement under this program, the case manager employed by the agency must meet the following required education/experience:

1. a Bachelor's or Master's Degree which includes a practicum encompassing case management practices or a major in Psychology, Sociology, Social Work, or related subjects, or
2. one year of qualified experience and an Associate Degree or 60 credit hours of college study from a regionally accredited college or university or one recognized by the New York State Education Department as following acceptable educational practices, or
3. two years of qualified experience and/or of case management experience, or
4. a degree in nursing or certification as a registered professional nurse or a licensed practical nurse with one year of qualified experience, or
5. qualifications meeting the regulatory requirements of a state agency for case manager.

Qualified Experience means verifiable full, part time or voluntary case management or case work with the following target populations:

1. persons with HIV related illnesses
2. women, children and families at risk of foster care
3. substance using families

B. Case Management Technician Qualifications

Case management technicians must have a high school diploma or equivalent or must be working towards a high school equivalency diploma (GED) at the time of employment, have one year of qualified experience and have received intensive training in the Case Management Technician curriculum developed by Hunter College, and shall work under the supervision of the case manager.

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c. Community Follow-up Worker Qualifications

The community follow-up worker, under the supervision of the case manager or case management technician, has no required educational or experiential requirements, but should have the following characteristics:

a. maturity, emotional and mental stability
b. ability to read and write, understand and carry out directions and instructions, record messages and keep simple records
c. be a resident or at least familiar with the local community and have knowledge of services and resources that are available
d. good physical health
e. a sympathetic attitude towards providing services to persons with HIV illness
f. fluency in local languages such as Spanish and Creole
g. experience working in the community preferable

In addition, the agency shall have the responsibility of assuring that all case managers, technicians and community follow-up workers employed (including volunteers) receive a 2-3 day orientation training within the first month of employment in the agency. Each agency must maintain a training log to document the provision of training to all employees.